101. What contractual commitments does WebMD have with the DoD for real-time system availability of the Pharmacy Data Transaction System (PDTS)? What penalties are imposed upon WebMD if they fail to meet this system availability target? Will the DoD consider a systems availability commitment to the contractor with associated penalties?

ANSWER: The system availability reports are attached. The Government will not hold the TMOP contractor accountable if it does not meet standards specified in the RFP due to PDTS unavailability resulting from Government action or inaction.

102. What has WebMD's system availability been for PDTS and Select Rx since program inception? Please provide statistics itemized on a monthly basis.

ANSWER: System availability reports from May 2001 through February 2002 are attached.

103. Who does DoD expect to perform customer service for the following functions: eligibility, Central Deductible and Catastrophic Cap File (CDCF), OHI, Coordination of Benefits, retail-to-mail DUR, MTF-to-mail DUR conflicts, out-of-stock prescriptions caused by Prime Vendor? Has the DoD considered the impact on the contractor's ability to handle customer service if the contractor's capability is compromised by WebMD's storage/administration of this information?

ANSWER: The contractor is responsible for customer service and will coordinate with the DoD PDTS Customer Service Center as necessary. DoD does operate a customer service phone line that beneficiaries may call at their option. Where necessary or applicable, the DoD customer service center will transfer calls to the contractor. It is anticipated that the contractor will also transfer beneficiary calls to appropriate government offices, e.g., eligibility issues or Medicare issues. Please refer to question 107 regarding the impact on customer service should PDTS not be available to assist in resolving a beneficiary call.

104. If the contractor is responsible for handling customer service, does the DoD expect the contractor to use Select Rx software to support customer service inquiries?

ANSWER: Yes, SelectRx is an integral part of PDTS that will assist the Contractor in performing Customer service.

105. If the expectation of the DoD is for the contractor to provide customer service relative to the data/information contained and housed in PDTS, will the DoD or WebMD be responsible for training new users? Based upon the Interface Control Document (ICD) for TMOP, the contractor is only allowed 10 concurrent users. Please explain the DoD's vision regarding how the combined prescription volume and customer call volume can be handled with only 10 concurrent users accessing PDTS. Please clarify and provide a detailed plan as to how DoD envisions this to be handled.

ANSWER: Yes, training for the Contractor will be performed by the Government. The number of concurrent licenses will be adjusted according to the needs/demands of the Contractor and the Program.

106. How would the DoD allow for the expansion of additional users on Select Rx and/or PDTS as prescription volume and customer service call volume increase during the life of the contract? Are there any associated fees or licensing costs be associated with this expansion? Who is responsible for the payment of these fees?

ANSWER: Additional users can be added at anytime, all users will be issued an individual PIN for security and monitoring purposes. The fees and licensing of SelectRx are Government costs, the Contractor is not responsible for the payment of these fees.

107. What consideration will be given to Customer Service performance and the beneficiary satisfaction incentive if PDTS performance and/or downtime adversely affects the outcomes of both measures? Who will determine this impact? What specific measures will the DoD employ and consider to determine the impact of PDTS performance and/or downtime on the contractor's Customer Service performance?

ANSWER: The contractor will not be held accountable for performance standards during periods that are impacted as a direct result of external systems performance and availability. Such incidents shall be brought to the immediate attention of the contracting officer for resolution. Given the historical reliability of PDTS, the Government does not anticipate any negative impact to beneficiary satisfaction resulting from any PDTS down time. However, in the event such a situation does arise, the Contracting Officer will evaluate the impact to beneficiary satisfaction and determine if adjustments to the survey sample are necessary.

108. What consideration will be given to performance of the prescription turnaround standards if PDTS downtime adversely affects turnaround time? Who will determine this impact? What specific measures will the DoD employ and consider to determine the impact of PDTS performance and/or downtime on the contractor's turnaround time?

ANSWER: The contractor will not be held accountable for performance standards during periods that are impacted as a direct result of external systems performance and availability. Such incidents shall be brought to the immediate attention of the contracting officer for resolution. Each alleged incident will be individually evaluated and resolved on a case by case basis.
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109. How does the DoD plan to test the eligibility interface among contractor, DoD and WebMD prior to the system going live? Will the DoD consider allowing an overlap period in order for the contractor to maintain

direct access to DEERS until there is 100% confidence in the interface through WebMD?

ANSWER: Testing will be as specified in the Interface Control Document. Access to DEERS will be through PDTS only. We anticipate PDTS connectivity with DEERS will be available for contractor testing within 30 calendar days of the date of award of this contract.

110. Please explain how the contractor is expected to build an eligibility record and determine what group the beneficiary/dependent should reside under since PDTS is now managing the eligibility verification process.

ANSWER: The solicitation has been amended to require the contractor to register patients, to include the documentation of any allergies declared by the patient or their representative, for the purpose of building a registration record in the contractor's systems for submission of eligibility requests through PDTS.

111. Please explain how the contractor will obtain the DDS code, considering DEERS houses this element and the contractor is required to include this value on the initial claims submission to PDTS.

ANSWER: DDS codes are only applicable for Legacy DEERS, this system is being terminated in favor of NEW DEERS at which point individual patient Ids will be the required. The Government is currently developing the interface and specification requirements which provides PDTS the ability to use multiple data sets from the Contractor to obtain the Patient ID through the eligibility determination process. The Patient ID will then be transmitted to the Contractor via the paid claim's response outlined in the ICD.

112. Please explain how the contractor is expected to identify branch of service, considering DEERS houses this element and the contractor is required to include this value on the initial claims submission to PDTS.

ANSWER: This information will not be required from the Contractor. PDTS will obtain the branch of service from DEERS during the eligibility process. The draft ICD will be modified to reflect this change.

113. Please clearly define how Other Health Insurance (OHI) will be facilitated through PDTS. Please confirm that a claim will reject if OHI indicates coverage with another benefit plan.

ANSWER: PDTS will contain an OHI database that will be checked during the eligibility inquiry. If a beneficiary has OHI, the TMOP contractor will be so notified and the prescription order shall be denied unless the exceptions in the RFP at C.4.1 have been met. PDTS will transmit a rejected claim's response as outlined in the ICD. The response will cite a reject code that

corresponds to a message notifying the Contractor that the patient is not eligible for services.

114. Please confirm that PDTS will adjudicate current copay logic and the planned 3-tier copay logic. How does the DoD envision that a contractor and the DoD will partner to create and support a dual claims processing scenario (i.e., the contractor adjudicates copay logic and WebMD adjudicates all other elements), given that this type of system exists nowhere in the PBM industry today?

ANSWER: The Contractor will submit, to the best of it's knowledge, the general co-pay applicable to each claim based on plan design. PDTS will determine the applicable co-pay after checking OHI/CDCF, etc., and transmit to the Contractor any changes in the submitted co-pay amount in the paid claim's response. The paid claims response to the Contractor will cite a code that corresponds to a message notifying the Contractor that the patient copay differs from the one the Contractor submitted to PDTS. The Contractor will be responsible for collecting from or crediting to the patient any difference in the co-pay amounts already submitted to the Contractor.

115. Please provide a claims processing flow chart which clearly outlines all transactions between the contractor and WebMD.

ANSWER: The claims processing requirements between the Contractor and PDTS are outlined in detail in the Interface Control Document.

116. The PDTS system requires patients to be identified via a new and old patient ID. Will both ID numbers be concurrently used (i.e., will new and old ID numbers be used concurrently for the same patient)? If not, when will the DoD cease the use of old ID numbers and implement the use of new ID numbers?

ANSWER: PDTS will seed the initial patient data base for the TMOP with the new patient Ids that correspond to the old legacy DEERS numbers. Patients using the TMOP for the first time will be required to complete a registration form. The patient information contained in the registration form (name, date of birth, sponsor name, SSN of sponsor etc) will be sent to PDTS. Upon receipt, PDTS will query DEERS for eligibility at which time PDTS will obtain the unique patient ID number and pass this number back to the Contractor in the paid claims response as described in Question 111.

117. For the new patient ID, is the ID assigned to each family member? If yes, then will all claims be submitted with a relationship code of (1) member? If no, please explain how the new patient ID will be assigned and how it should be used to submit a claim for dependents (spouse and children).

ANSWER: The new patient ID is a unique ID number for each family member. The ID number will not be reassigned and follows the family member throughout

their life cycle. The relationship code will be used in circumstances where the Contractor is passing information to PDTS without a patient ID (for example a first time TMOP user). Once the TMOP database is populated with the patient ID (by either the seed file or the paid claims response described in #116), the Contractor will be required to send the patient ID on subsequent claims.

118. Please explain in detail how the DoD plans to inform DoD beneficiaries regarding the new patient ID number.

ANSWER: DoD plans for informing DoD beneficiaries regarding the new patient ID will be provided to the contractor once these plans are finalized and approved for release. The TMOP contractor is not tasked under this solicitation to be involved in that process. PDTS will provide the Contractor with the Patient ID number if the Contractor is filling a prescription for the patient for the first time. Please see Question 111.

119. Under the section "Services to be Provided" in the TMOP Interface Control Document (ICD), it indicates that drug data will be established by PDTS. Does this mean that PDTS will perform all drug coverage verification rules, including covered/not covered, days supply/days supply limitations, prior authorization requirements, medical necessity requirements, quantity rules, and duration rules? Please confirm for each element listed above.

ANSWER: All plan design requirements will be adjudicated by PDTS.

120. Will the government consider a market-based standard for prescription turnaround time, given that 100% compliance to prescription turnaround is not realistic?

ANSWER: Absent data indicating otherwise, we believe the standards listed in the RFP are reasonable.

121. Please provide detailed definitions of a TED Validity Edit and TED Provisional Edit. Please provide a list of all data elements evaluated. Are there fixed or variable thresholds that a claim must meet on each data element?

ANSWER: All edits and data elements are defined in the TRICARE System Manual which is available through the TMOP solicitation web site.

122. Which specific data elements will PDTS review to determine if a submitted TED record by the contractor is acceptable?

ANSWER: PDTS will require the Contractor to submit a complete set of data elements for each prescription order. PDTS will populate and produce the TED

based on the data submitted by the contractor to include any adjusted data elements included in the paid claim's response such as co-pay or Patient ID.

123. Will the DoD consider allowing either the contractor or WebMD to perform all DUR edits on all points-of-service (retail-to-mail, MTF-to-mail, and mail-to-mail), given the burdensome nature of any industry contractor managing dual DUR systems in a planned WebMD hard-edit environment?

ANSWER: PDTS will perform ALL DUR edits.

124. What contractual commitments do retail pharmacy contractors have to market retail-to-mail migration? How often? Are there any specific materials they are required to send?

ANSWER: There is no such requirement. All marketing activities relating to the TMOP will be performed by the TMOP contractor.

125. Is there a monthly billing and/or audit process?

ANSWER: Please clarify your question. To what are you referring?

126. Is there a pricing audit or clinical audit? Are there any other audits potentially expected of the contractor? If yes to any of these, please describe the auditing process in detail, including frequency of audits, and describe the contractor's specific responsibilities for these audits.

ANSWER: Please clarify what is meant by "clinical audit". With regards to pricing, several fields in the data transmission from the Contractor to PDTS will be checked on-line for validity. The ingredient cost field will be validated by comparing the submitted ingredient cost from the Contractor with the Managed Care Pricing File to identify transactions which fall out of agreed upon tolerance ranges. Fields that will also be validated will be administrative fee, co-pay, sales tax (if applicable), and submitted amount due. Transactions that fail the validity test will be rejected back to the Contractor via a rejected claims response along with the proper standard NCPDP reject code so the Contractor can identify the potential error and prepare a corrected claim for resubmission. The Government may also perform audits relating to program integrity, fraud and abuse detection, quality control and program management. Additionally, throughout the life of any Government contract there is the potential, dependent upon dollar thresholds and the types of contractual actions, for various audits including financial capability, estimating, accounting, property, purchasing, billing and compensation. Any changes to existing contract requirements may have potential audit implications. Terms, conditions, certifications and clauses contained within the RFP, especially those at Sections I, K and L, identify areas for potential Government audit.

127. Can the contractor follow its own commercial business practices in attempting to retrieve uncollected copays from beneficiaries? What support

will the DoD offer? Since the beneficiary copay is used in the calculation of the contractor's administrative fee, will the government make the contractor whole for non-payment by beneficiaries at any point in the process?

ANSWER: The contractor may use its normal business practices to collect short or delinquent co-pays from beneficiaries, consistent with the terms and conditions of this solicitation and 32 CFR 199. DoD will not be involved in this process. The contractor will be wholly responsible for collecting these amounts. The RFP has been amended to reflect this. The contractor shall not refer debts to an outside debt collection agency without first obtaining written approval from the Contracting Officer.

128. Reference C.4.2.2: "...The contractor is expected to support a three-tiered co-pay system." When the three-tiered co-pay system is implemented, will this be issued via change order with the opportunity for the contractor to submit a proposal for additional administrative costs or development fees?

ANSWER: A change order will be issued implementing the three-tiered co-pay system. The RFP (Section L.12.e.) requires that the offeror plan for this change so that any changeover or implementation costs will be minimal.

129. Please provide a complete TED record file layout without reference to attachments or web sites because these do not provide access to the information.

ANSWER: The TED record file layout is available in the TRICARE System Manual, Chapter 2, Section 2.2, which is available on the TMOP Solicitation web site. The Government is soliciting this requirement entirely on-line with no hard copy information provided.

130. Section C.4.2: Please clarify the specific uses and/or requirements regarding the request for prescriptions to be received by the contractor via "electronic" media. Are there similar or different requirements/expectations for new and refill prescriptions?

ANSWER: The contractor shall allow refill orders to be submitted electronically over its web site. New orders may be accepted in a similar fashion if allowed under Federal and State law.

131. How will the contractor determine the valid licensure of overseas physicians if the contractor is required to accept overseas prescriptions via fax?

ANSWER: Overseas physicians practicing in Military Treatment Facilities are credentialed by the Military Treatment Facility in which they practice. Any questions that cannot be resolved concerning the validity of the overseas

license should be directed to the PDTS Customer Service Support Center (CSSC). The prescription should be pended until the CSSC can resolve the issue. The CSSC typically resolves these types of issues today in one (1) business day. Once resolved the CSSC will notify the Contractor so they may proceed with the processing of the prescription.

132. We were unable to locate details regarding the patient appeal process in the TRICARE Systems Manual. Can you either provide the specific section location in the manual where this information can be located or provide details regarding this process, including the required written text, patient rights, requirements of the contractor and timing associated with executing these appeals?

ANSWER: Patient appeal rights are detailed in 32 CFR 199.10.

133. Section 4.3.4: What is a voucher? How is it similar or different to a TED record?

ANSWER: A voucher or batch is a grouping of TEDs detail records combined into a single electronic file to be transmitted to TRICARE. All detail TEDs records grouped into a file will have a header record at the beginning of the file. There are three types of header records;

Batch (Header Type 0)
Voucher (Header Type 5)
Claim Rate Voucher (Header Type 6)

PDTS will use the Claim Rate Voucher (Header type 6) for ALL TMOP submissions. The header type tells TEDs what kind of edits to perform and (in the case of the TMOP contract) to count claims for administrative payment. Further information may be found in the TSM Chapter 2.

134. Will there be a COTR assigned to the TMOP? If so, what will his or her responsibilities be?

ANSWER: Yes. A Contracting Officer's Representative will be assigned and delegated specific responsibilities, by the Contracting Officer, for monitoring the contractor's performance.

135. What is the turnaround submission time to TMA when the contractor submits a corrected/adjusted TED record to PDTS? Is it necessary for the corrected/adjusted TED record to be held by PDTS until the 11th calendar day as with the original TED record or is it reinserted to its previous location in the queue?

ANSWER: Corrected TEDs will be reinserted in the queue where they were originally located. For example, if a transaction submitted on Day 1 is rejected due to TED requirements, the resubmitted claim will fall into the queue as a Day 1 transaction and be submitted for payment on Day 11. If a

transaction is rejected on Day 13 due to TED requirements, the transaction will be submitted for payment immediately upon resubmission by the Contractor as long as the transaction meets the TED requirements when resubmitted.

136. Section C.4.6: If the DoD P&T Committee continues to make quarterly formulary changes, the cost of updating, re-printing and maintaining up-to-date formulary guides for beneficiaries is extremely expensive and time consuming. Will the DoD consider an alternative form of beneficiary communication to be mutually agreed upon, such as a web site link provided in communications materials?

ANSWER: There is no requirement to publish or print a formulary. The contractor may direct beneficiaries to the PEC web site where the formulary is listed. The contractor's customer support personnel should be aware of this web site when responding to questions on formulary availability and anticipated applicable co-pays.

137. Section C.4.8.1.6: Despite best efforts, it is not always possible for a contractor of any prescription program to resolve 100% of all customer service issues within 24 hours. Will the DoD consider a modification of this performance measurement to a mutually agreed upon target?

ANSWER: No. We believe this to be a reasonable standard. The Government is willing to consider this issue further if the offeror can provide specific examples where the standard may be unachievable.

138. Section H.2: We are concerned that the planned sample size of 400 beneficiaries (as discussed at the March 13 pre-proposal conference) to be polled on a quarterly basis to determine beneficiary satisfaction is an insufficient sampling size. What is the specific methodology that the DoD will employ to determine a relevant sample size of beneficiaries to participate in the Beneficiary Satisfaction Survey? If the DoD is unable to obtain a minimum sample of 400 beneficiaries, how will determination be made in a particular quarter regarding the contractor's satisfaction rating?

ANSWER: The target response pool of 400 was developed with an interest to achieve an estimate of "percent satisfied" to three percentage points on a one hundred point scale with 95 percent confidence. It is assumed that approximately 90% of TMOP users will be satisfied with services and that the distribution of responses to the overall satisfaction item will be binomial (i.e. satisfied, not-satisfied). A binomial distribution with p = 0.9, a 95% confidence interval with half length .03 (i.e. +/- 3%) requires a sample of about 400.

The calculation is: using the normal approximation to binomial distribution, .03=~2*SD & SD=~sqrt(p(1-p)/n)=sqrt(.9*.1/n). This means that .015=sqrt(.9*.1/n), so sqrt(n)=.3/.015=20, or n=400.

Telephone survey efforts will continue until 400 completions are accomplished from this frame. The telephone survey process will not be considered final until attaining 400.

139. Please confirm that medical necessity review includes, but is not limited to, a dialogue between the contractor's pharmacist and the prescribing physician to evaluate the clinical/medical use of a non-formulary/preferred drug, based upon clinical criteria established by the contractor and/or the DoD P&T Committee. Please provide any other definitions of medical necessity.

ANSWER: A medical necessity review may include, but does not necessarily require, a dialogue between the contractor's pharmacist and the prescribing physician to evaluate the medical necessity to use a non-formulary drug. For example, if the prescription is accompanied by information from the prescriber that substantiates the medical necessity to use a non-formulary drug, a dialogue with the prescribing physician is not necessary.

140. How many or what percentage of claim records does the DoD expect will typically generate a return by PDTS for missing or invalid information on the TED record? Is there a comparable performance measurement as part of the current HCSR process to evaluate the level, frequency and cost of intervention needed on returned TED records?

ANSWER: As long as the Contractor submits all claims in accordance with the ICD, the percent of returned claims should be less than one half of one percent. Comparable figures for current pharmacy record rejection do not exist since we do not currently "Provisionally accept" records.

141. Regarding the TED accuracy requirements referenced in sections C.3.4.1 through C.4.3.6, reference is made to 'Provisional' and 'Validity' edits. Upon thorough review of the TRICARE Systems Manual, the only reference to these two edit categories contained in the TRICARE Systems Manual is in Chapter 2, section 3.1, which states "Chapter 2, Section 3 through Section 8 contain a list of error messages sequenced by ELN". However, the current version of the TRICARE Systems Manual does not contain these referenced sections (chapter 2 only goes as high as section 3.1), and it appears the manual does not provide any detail on 'relational', 'provisional', or 'validity' edits and related error codes. What is the specific location of detailed descriptions for these edits?

ANSWER: Chapter 2, Section 3.1, paragraph 4.0 of the current version of the TRICARE Systems Manual located on the procurement web site states "Chapter 2, Sections 4.1 through Section 9.1 contain a list of error messages sequenced by ELN. The top right part of each page identifies the type of record or records to which the edit applies. There are two parts to each edit - the validity edits and the relational edits." Detailed descriptions of "validity" and "relational" edits are given in Chapter 2, Section 3.1. Section 3.1 also provides information on the "provisional acceptance" of TEDS with relational edit errors.

142. When a contractor needs to verify eligibility coverage status through PDTS for a beneficiary outside of the claim adjudication function (e.g., to support the Call Center/customer service function), will PDTS require the eligibility inquiry transaction to be via the E1 component of the NCPDPv5.1 format? If not, then what eligibility inquiry transaction format will be required by PDTS?

ANSWER: Yes, PDTS will support an E1 eligibility inquiry transaction in NCPDP 5.1 format. The TMOP ICD Version 5.1 will be amended at a future date to include this requirement.

143. C.4.2 makes reference to "TMOP registration forms." Are we correct to assume the "registration form" is a standard mail order form that a beneficiary would submit with his or her prescription.

ANSWER: This refers to the offeror's standard form used to develop patient profiles and will only be required when beneficiaries submit their first prescription order. There should be no need for subsequent submittals of the registration form unless the beneficiary has a change in status, e.g., a change in allergy status or a new address. The contractor may remind beneficiaries to update their profile through its marketing program.

144. At what point (dollars and age) will the DOD be responsible for any past due members accounts receivable balance?

ANSWER: Amendment 0001 clarified the requirement for debt collection. Please refer to Section C.4.2.3 as amended. It makes the contractor wholly responsible for collecting any short or delinquent co-pay amounts.

145. Once the level has been reached in #144 above, what will be the mechanism to get DOD reimbursement for these member accounts?

ANSWER: Not applicable as the contractor is wholly responsible for collecting short or delinquent co-pay amounts per Amendment 0001.

146. To protect the DOD on #144 above, ESI currently has a policy of holding orders >$40 and 90 days of age until payment is received. The $40 level would equate to between 3 & 4 orders outstanding. We would ask that the DOD adopt our current policy.

ANSWER: Amendment 0001 to the RFP specifies at C.4.2.3., debt collection requirements and thresholds. The contractor will be required to comply with these requirements.

147. After DoD implements 3-tier copays, there will be circumstances of zero-balance-due claims - where the actual claim cost will be lower than the plan copay. It is anticipated that DoD will require that the contractor only charge the lesser amount in such cases, rather than charging the full plan copay for a tier. Likewise, it is anticipated that DoD will expect the contractor to determine the 'lower' member copay for zero-balance-due claims

based on the Federal Supply Schedule, not on the contractors' internal drug price or MAC price. Is this assumption correct ?

ANSWER: Where the actual prescription cost is less than the plan co-pay, the beneficiary will only be charged the lesser amount. Actual prescription cost will be based on the DSCP Managed Care Pricing File as submitted to and adjudicated by PDTS.

148. Although the documentation provided by DoD on the TED billing file record does not specify what cost basis should be used to populate cost fields such as "amount billed", it is anticipated that DoD will expect this to be derived from FSS pricing tables, not from the contractors' internal pricing. Is this assumption correct?

ANSWER: Amount billed pricing relating to prescription cost shall be based on the DSCP Managed Care Pricing File (MCPF). The MCPF includes FSS pricing as well as other contract pricing extended to the TMOP operation as submitted to and adjudicated by PDTS.

149. C.4.8 states that the contractor must provide "international toll free numbers". Can you be more specific to how many international toll-free numbers will be required and to what countries this requirement applies?

Answer: The following is a list of OCONUS locations to which DoD NMOP Program prescription orders were shipped between March 2001 and February 2002. The PDTS Customer Service Center maintains a toll-free telephone number that beneficiaries may call from around the world. The Government will provide this number to the contractor to market to OCONUS beneficiaries. An option to be transferred to the TMOP contractor will be added to this menu tree for this number. This will eliminate the need for the contractor to establish toll-free numbers for OCONUS beneficiaries. The solicitation will be amended to reflect this change.

American Samoa (AQ)	Argentina (AR)	Aruba (AA)	Australia (AS)
Bahrain (BA)	Belize (BH)	Botswana (BC)	Cape Verde (CA)
China (CH)	Costa Rica (CS)	Egypt (EG)	France (FR)
Germany (GM, GE)	Greece (GR)	Guam (GQ, GU)	Honduras (HO)
Iceland (IC)	India (IN)	Indonesia (ID)	Israel (IS)
Italy (IT)	Jarvis Island (JA)	Jordan (JO)	Maldives (MV)
Mexico (MX)	Mongolia (MG)	Netherlands (NL)	New Zealand (NZ)
Northern Mariana Islands (CQ)		Norway (NO)	Panama (PM)
Papua New Guinea (PP)	Philippines (RP)	Puerto Rico (RQ, PR)	
Saudi Arabia (SA)	Singapore (SN)	South Africa (SF)	Spain (SP)
Switzerland (SW)	Taiwan (TW)	Thailand (TH)	Turkey (TU)
Turkmenistan (TX)	Ukraine (UP)	United Kingdom (UK)	
Virgin Islands (VQ, VI)			

Alaska (AK)
Hawaii (HI)

150. According to Section XVIII.B of the ICD, PDTS will only perform Therapy Duplication and Drug-to-Drug Interaction edits for claims having different chain ID's. Based upon this, it is our understanding that the contractor must perform mail-to-mail DUR (i.e., mail claims have the same chain ID). Please confirm, because the response to Question 123 indicates that PDTS will perform all DUR edits.

ANSWER: The answer to Question #123 was correct. The DRAFT ICD will reflect in the next edition that ALL DURs for the TMOP will be performed by PDTS.